STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE COMPL	ETED	
			B. WIN	G		04/02	/2014
	PROVIDER OR SUPPLIER			8480 CF	ADDRESS, CITY, STATE, ZIP CODE RAIG ST APOLIS, IN 46250		
DERNOH	IRE OF CASILEIC	лч 		INDIAN	APOLIS, IN 40250		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL AGG DENTERVING DEFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)	ATE	(X5) COMPLETION DATE
R000000	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE,		DATE
			R00	00000			
	This visit was for a Licensure Survey	State Residential					
	Survey dates : Ma	rch 31, April 1 & 2, 2014					
	Facility number :00 Provider number : AIM number : N/A Survey Team: Mic Census bed type: Residential : 124	009894					
	Census payor type Other: 124	e:					
	Sample : 7						
	These state finding with 410 IAC 16.2.	gs are cited in accordance					
R000092	by Brenda Meredit 410 IAC 16.2-5-1.3 Administration and Noncompliance (i) The facility must and disaster prepare continuity of care of emergency as follows: (1) Fire exit drills in transmission of a facility must be simulation of emerence except that the more residents to safe at the building is not conducted quarter familiarize all facility.	d (i)(1-2) d Management - t maintain a written fire aredness plan to assure of residents in cases of ows: In facilities shall include the fire alarm signal and regency fire conditions, ovement of nonambulatory areas or to the exterior of required. Drills shall be					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

State Form Event ID: IB1V11 Facility ID: 009894 If continuation sheet Page 1 of 12

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	(X3) DATE COMPL 04/02 /	LETED	
			B. WING		04/02/	12014
	ROVIDER OR SUPPLIER		8480 C	ADDRESS, CITY, STATE, ZIP CODE RAIG ST JAPOLIS, IN 46250		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	N BE RIATE	(X5) COMPLETION DATE
R000216	conditions. At least held every year. Whetween 9 p.m. are announcement manually additionable alarms. (2) At least every shall attempt to he drill in conjunction department. A received shall be document signatures of the properties of the properties. Based on interview facility failed to hastire department every facility failed to hastire department every facility failed to hastire department of performed with the fire drill book properties. In an interview with 4/1/14 at 2:00 P.M. thought the drills whad to be done yet facility only had or department in 2010. 410 IAC 16.2-5-2(Evaluation - Noncompany of the scope and shall be delineated manual, but at a manual, but at a manual of the scope.	st twelve (12) drills shall be when drills are conducted and 6 a.m., a coded and be used instead of six (6) months, a facility old the fire and disaster with the local fire ord of all training and drills ted with the names and personnel present. We and record review, the very fire drills with the local fire or and fire drills with the local fire of a fire drill attempted or a fire drill attempted or a local fire department in provided. The training and drills the local fire drill attempted or a local fire department in provided. The training and drills the local fire drill attempted or a local fire department only arly. She indicated the fire department only arly. She indicated the fire drill with the fire 3.	R000092	No Residents residing in the community were affected by deficient practice. No other residents were affected by deficient practice. The facility attempt to hold a fire and didrill in conjunction with the lifter department at least ever months. Past fire and disast drills documentation will be reviewed for compliance an record of all training and dribe documented. The maintar director/designee will conduct document fire and disaster in accordance with the state regulation and Brookdale Lipolicy and procedure. The executive director/designee monitor fire and disaster dri quarterly times 2 and review results with safety committee ensure the deficient practice not recur. Systemic change be completed by 4/16/2014	y this ty will saster ocal ry six ter d a tlls will nence tct and drills vings will tv e, to e will	04/30/2014

State Form Event ID: IB1V11 Facility ID: 009894 If continuation sheet Page 2 of 12

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING O O O O O O O O O O O O O			ETED		
			B. WING			04/02/	/2014
	F PROVIDER OR SUPPLIEI SHIRE OF CASTLET(84	480 CRA	DRESS, CITY, STATE, ZIP CODE AIG ST POLIS, IN 46250		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	IE PRE TA		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	mental status. (2) The resident 'activities of daily I (3) The resident 'admission and se (4) If applicable, the self-administer metal (4) The evaluation writing and kept in the self-administer metal (5) Based on intervier facility failed to we for 2 of 5 resident (7) Resident #1 and to complete self in the residents administ medications. This reviewed for evaluation (7) Residents #104, Findings include: 1. On 3/31/14 at for Resident #67 included, but were artery disease, dia the physician's of indicated the resident medicate. The weight book weights for 2013 in documented for Findings in the self-administration of the self-adminis	s weight taken on miannually thereafter. The resident 's ability to edications. In shall be documented in the facility. We and record review, the eigh residents semiannually is reviewed for weights. #67) The facility also failed nedication evaluations for tering their own is affected 2 of 5 residents justions in a sample of 7. #67) 11 A.M. the record review was completed. Diagnoses is not limited to, coronary abetes and high cholesterol. Indeed, and the reviewed. The only weight desident #67 was from sumentation found on self	R00021		Residents #1 was weighted immediately and place on recoto be weighted in semiannually. Orders were obtained from ME identify medications that are seadministered. Resident #67 was weighted immediately and planced on records to be weighted in semiannually. Ordewere obtained from MD to idented in the interest of the residents having the potential to be affected by the same deficient practice by auditing weight records and medication administration record the residents who reside in the community. No other residents were identified. Semiannually the interest of the residents who reside in the community will receive a re-weight and re-self administration evaluation along with the scheduled re-assessment semiannually. Records will be review weekly weeks. The corrective actions be monitored by the healthwellness director/design to ensure the deficient practice.	y.) to elf as ers ord the s he	04/30/2014

State Form Event ID: IB1V11 Facility ID: 009894 If continuation sheet Page 3 of 12

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/02/2014		
			B. WING		04/02/2014	
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 8480 CRAIG ST INDIANAPOLIS, IN 46250			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID		(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP	ECTION	
TAG	`	R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE AP DEFICIENCY)	PPROPRIATE DATE	
1710		0 P.M., the Director of	1710	will not recur.Completed		
	Nursing (DoN) inc	dicated she could not locate from 2013 or a self		4/30/2014		
	, ,	sment for Resident #67				
		self medicate. There was				
		which indicated the				
		assessed to self medicate.				
	2. On 3/31/14 at	10:00 A.M., the record				
		nt #1 was completed.				
		ed, but were not limited to,				
	_	e pulmonary disease and				
	mild dementia.	.,				
	The physician's o	rders indicated on 8/7/13				
	there was an orde					
		3(2.5) milligrams/3 milliliters				
		times a day (resident self				
	administers)"	• •				
	The nurses notes	indicated on 12/2/13,				
		peen self administering				
	nebulizer"	een sen administering				
		cumentation found for a self sment for Resident #1.				
	medication asses	SINGILIUI NESIUCIII#1.				
	3. On 3/31/14 at	2:00 P.M., the record review				
	for Resident #104	was completed.				
	_	ed, but were not limited to,				
	diabetes, coronar	y artery disease, and				
	congestive heart f	failure.				
	The weight book (documentation indicated				
		not have weights recorded.				
	On 3/31/14 at 3:0	0 P.M., the Director of				
	Nursing (DoN) inc	dicated she could not locate				
	any weights from	2013 for Resident # 104.				
	During an intervie	ew on 3/31/14 at 3:00 P.M.,				
	_	rsing (DoN) indicated she				
	me Director or INA	inaning (Doin) indicated affe				

State Form Event ID: IB1V11 Facility ID: 009894 If continuation sheet Page 4 of 12

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/02/2014
			B. WING		04/02/2014
	ROVIDER OR SUPPLIER		8480 (ADDRESS, CITY, STATE, ZIP CODE CRAIG ST NAPOLIS, IN 46250	
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	1	(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	· ·	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
IAU			IAG		DATE
R000217	for Resident #104. 410 IAC 16.2-5-2(e Evaluation - Deficie (e) Following comp the facility, using a members, shall ide services to be prove follows: (1) The services of resident shall be a (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services of and revised as app the resident and facth and revised as app the resident and facth and revised and dated be copy of the services resident upon reque (4) No identification services provided a subsequent to the no need for a char	esident #1 or 2013 weights e)(1-5) ency Deletion of an evaluation, ppropriately trained staff entify and document the vided by the facility, as ffered to the individual ppropriate to the: ffered shall be reviewed propriate and discussed by ecility as needs or desires facility or the resident vice plan review. On service plan shall be by the resident, and a e plan shall be given to the est. In and documentation of its needed if evaluations initial evaluation indicate enge in services.			
		n of medications or the ntial nursing services, or			
		licensed nurse shall be			
	involved in identific	cation and documentation			
	of the services to b	pe provided.			
	facility failed to inc	v and record review, the lude all medication esident on the service plan	R000217	Resident #1 service plan was updated. An audit of the patie service plan will be completed identify other residents affected by the deficient practice. No	to
	for 1 of 5 reviewed sample of 7. (Residue)	for service plans in a dent #1)		other residents were identified being affected by the same	las

State Form Event ID: IB1V11 Facility ID: 009894 If continuation sheet Page 5 of 12

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/29/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUI					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPL	ETED
			B. WIN			04/02/	/2014
			D. WIN		ADDRESS CITY STATE 718 CODE		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
DEBKO	IDE OF 040TI FT0	***			RAIG ST		
BERKSH	IRE OF CASTLETC	JN		INDIAN	APOLIS, IN 46250		
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES		ID	DDOWIDED'S BLANCE CODDECTION		(X5)
PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	IE.	DATE
		•			deficient practice. A evaluation	n	
	Findings include:				of the residents needs will be		
	i mango molado.				completed prior to admission in	nto	
	On 3/31/14 at 10:0	00 A.M., the record review			the community, every six month		
	for Resident #1 was completed. Diagnoses				with change of conditions and		
		not limited to, chronic			needed. The deficient practic		
		nary disease and mild			will be monitored by the		
	dementia.	.a., alocado alla lillia			healthwellness director/design	ee.	
	23				Evaluations will be audited we		
	The physician's or	ders indicated on 8/7/13			x4, monthly X 1 and quarterly		
	there was an order				thereafter. Completed by		
		3(2.5) milligrams/3 milliliters			4/30/2014		
		times a day (resident self					
	administers)"						
	dariii ilotoro)						
	The nurses notes i	indicated on 12/2/13,					
		een self administering					
	nebulizer"						
	On 3/31/14 at 3:10	P.M., the Director of					
		icated there was no					
		elf medicating of nebulizer					
		service plan dated 2/7/14					
	for Resident #1.						
R000298	410 IAC 16.2-5-6(d	c)(2)	İ				
		ervices - Deficiency					
	(2) A consultant ph	-					
		er contract, and shall:					
		for the duties as specified					
	in 856 IAC 1-7;	•					
		g handling and storage					
	practices in the fac						
		tation on methods and					
	procedures of orde						
	_ · · ·	disposing of drugs as					
	well as medication						
		ig, to the administrator or					
		e any irregularities in					
	dispensing or adm	inistration of drugs; and					
		g regimen of each resident					
	, , ,	rvices at least once every					
	sixty (60) days.	-					

State Form Event ID: IB1V11 Facility ID: 009894 If continuation sheet Page 6 of 12

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIIII	DDIC	00	COMPL	ETED
				LDING		04/02/	2014
			B. WIN		ADDRESS CONT. STATE JID CODE		
NAME OF I	PROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP CODE		
					RAIG ST		
BERKSH	IIRE OF CASTLETO	ON		INDIAN	APOLIS, IN 46250		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TC	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG CROSS-REFERENCED TO THE APPROP			DATE
			R00	0298	A drug regiment was complete	- ₇ d	04/30/2014
			100	.0200	for resident #119. A drug	, u	0 1/3 0/2011
	Based on interviev	w and record review the			regiment was completed for		
	facility failed to en	sure the pharmacy was			resident #4. A audit of the		
	performing drug re	egimen reviews on all			pharmacy evaluations was		
	residents every 60	days for 2 of 5 residents			completed to identify other		
		macy recommendations in			residents that have been affect	ted	
	a sample of 7. (R	esidents # 119 and #4)			by the deficient practice. No		
					other residents were affected.	Α	
	l =		patient roster will be used to		COMPLETION		
					identify residents receiving a d	Irug	
	1. On 4/1/14 at 12:30 P.M. the record review for Resident #4 was completed. Diagnoses included, but were not limited to, Stage III				regimen by pharmacy. The		
					corrective actions will be		
					monitored by healthwellness		
		etes, myasthenia gravis,			director/designee. On monthly	•	
		eves disease. The resident			pharmacy visits, the		
	was admitted Jani	uary 24, 2003.			HWD/designee will compare		
	On 2/21/14 the Di	rector of Nursing (DeN)			reviewed residents to resident		
		rector of Nursing (DoN)			roster to ensure all residents		
		acy book which she nave all of the medication			receiving medication		
		done for all of the residents			administration are reviewed ev	•	
	_	t date. She indicated those			60 days. This will be complete		
		re self medicating may not			monthly.Completed by 4/30/20) 14	
		ne on them since they are					
	independent with						
	The pharmacy rev	view dates for Resident #4					
		/4/14, 1/8/14, and 7/3/13.					
	2. On 4/1/14 at 10	0:30 A.M. the record review					
	for Resident #119	was completed.					
	_	ed, but were not limited to,					
		ive heart failure and stroke.					
	The resident was	admitted 1/10/14.					
	Th	and the second s					
		cumentation found for a					
	arug regimen revi	ew for Resident #119.					
	On 4/1/14 at 2:00	D.M. the DeNindicated					
		P.M., the DoN indicated					
		why the reviews were not					
	completed as they	/ Snould be.					

State Form Event ID: IB1V11 Facility ID: 009894 If continuation sheet Page 7 of 12

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
			B. WING		04/02/2014
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER			RAIG ST	
BERKSH	IRE OF CASTLETC	DN		APOLIS, IN 46250	
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
R000354	provided an undat "Pharmacy Product Agreement" indicat with Healthcare Lat material respects or regulations rules, of 410 IAC 16.2-5-8. Clinical Records - (g) A transfer form following: (1) Identification do (2) Name of the tra (3) Name of the red date of transfer. (4) Resident 's pe transferred to an ar (5) Nurses 'notes s: (A) functional ability limitations; (B) nursing care; (C) medications; (D) treatment; and (E) current diet and (6) Diagnosis. (7) Date of chest of tuberculosis. Based on interview facility failed to have information complete resident to the hos records reviewed if #126) Findings include:	ated, "6.1 Compliance awswill comply in all with all applicable statues, orders, ordinances" 1(g)(1-7) Noncompliance a shall include the ata. ansferring institution. aceiving institution and arsonal property when acute care facility. a relating to the resident ' aties and physical d condition on transfer. a-ray and skin test for av and record review, the ave all of the transfer acted prior to sending a appital for 1 of 2 closed an a sample of 7. (Resident	R000354	Resident #126 no longer resid at community. No other reside was affected by this deficient practice. An inservice will be completed to train staff on the proper documentation of the emergency paperwork. Deficipractice will be monitored by healthwellness director/design weekly X 4, monthly X 1 and quarterly thereafter. complete by 5/16/2014	ent ent ee

State Form Event ID: IB1V11 Facility ID: 009894 If continuation sheet Page 8 of 12

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED			
AND PLAIN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING	00	04/02/2014		
			B. WING	ADDRESS, CITY, STATE, ZIP CODE	1		
NAME OF P	PROVIDER OR SUPPLIEF	R					
BERKSH	IRE OF CASTLETO	ON	8480 CRAIG ST INDIANAPOLIS, IN 46250				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE	RIATE		
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		
	irritable bowel syn	ed, but were not limited to, idrome, diastolic heart diverticular bleeding.					
	sent to the hospita "pacemaker spark breath." The docu Transfer or Discha and address of the	indicated the resident was all on 10/15/13 due to her king and resident short of ument titled "Notice of arge" only had the name a facility and the local me information provided, cument was blank.					
	dated 10/15/13, hand date of birth, to, the physician rethe facility address diagnosis at time diagnosis at complete the diagnosis at time	sfer discharge document ad the name of the resident hospital it was transferring name and phone number, s and phone number and of transfer being arked." There were no vital n of the resident being short					
R000355	Director of Nursing 126 was very index the reason there we documentation fills 410 IAC 16.2-5-8. Clinical Records - (h) Current clinical completed prompt discharged reside	ed out. 1(h) Nonconformance I records shall be					
	facility failed to ha information compl	w and record review, the ve all of the clinical record eted within 70 days of 2 closed records reviewed (Resident #126)	R000355	Resident #126 no longer res at community. No other resi was affected by this deficien practice. An inservice will b completed to train staff on the proper documentation of the emergency paperwork. Defi	dent t e e		

State Form Event ID: IB1V11 Facility ID: 009894 If continuation sheet Page 9 of 12

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO		(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00		LETED
			B. WING			2/2014
			STREET	ADDRESS, CITY, STATE, ZIP	CODE	
NAME OF F	PROVIDER OR SUPPLIEF	t		RAIG ST		
BERKSH	IRE OF CASTLETO	ON		IAPOLIS, IN 46250		
(X4) ID	SUMMARVS	TATEMENT OF DEFICIENCIES	ID	Ī		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION	ORRECTION SHOULD BE	COMPLETION
TAG	·	LSC IDENTIFYING INFORMATION)	TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	DATE	
1710	REGUESTIONT ON	Egg iblivin Thio his ordinition)	1710	practice will be monit	ored by	DITTE
	Findings include:			healthwellness direct		
	- manage motores			weekly X 4, monthly 2	•	
	1. On 4/1/14 at 10	0:40 A.M. the record review		quarterly thereafter.		
	for Resident #126			by 5/16/2014		
	_	ed, but were not limited to,				
	•	drome, diastolic heart				
	aystunction and d	iverticular bleeding.				
	The nurses notes	indicated the resident was				
		al on 10/15/13 due to her				
	· ·	ing and resident short of				
		ument titled "Notice of				
		arge" only had the name				
		e facility and the local				
		ne information provided,				
	the rest of the doo	cument was blank.				
	The resident disch	narge summary indicated				
		d out on 11/12/13.				
	There was no "No	tice of Transfer or				
	_	nentation completed. The				
		no indication of the reason				
	for discharge and	where the resident went.				
	On 4/1/14 at 11:20	O A.M., the Director of				
		that Resident # 126 was				
	-	and that this was the				
		no transfer documentation				
	filled out.					
R000410	410 IAC 16.2-5-12					
	Infection Control -					
		uberculin skin test shall be				
	•	three (3) months prior to admission and read at				
	· ·	seventy-two (72) hours.				
		e recorded in millimeters of				
		e date given, date read,				
		ninistered and read.				
	,	ho have not had a				
	documented nega	tive tuberculin skin test				
			1	I		I

State Form Event ID: IB1V11 Facility ID: 009894 If continuation sheet Page 10 of 12

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/02/2014	
	OF PROVIDER OR SUPPLIED		8480 0	ADDRESS, CITY, STATE, ZIP CODE CRAIG ST NAPOLIS, IN 46250	•
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	months, the base should employ the first step is negative be performed with weeks after the fir repeat testing will infection with tube (g) All residents who to the tuberculin sto have a chest x-laboratory examinal diagnosis. Based on intervieing facility failed to contests at admission residents reviewed (Residents #119, Findings include: 1. On 4/1/14 at 1 for Resident #119 Diagnoses included diabetes, congest The resident was P.M. The MAR (Medicator January 2014 received a 1st step Derivative) on 1/1 This was 2 days at 2. On 3/31/14 at for Resident #67 included, but were included.	who have a positive reaction ikin test shall be required aray and other physical and rations in order to complete where and annually for 2 of 5 d in a sample of 7. #67, #1) 0:30 A.M. the record review was completed. ed, but were not limited to, ive heart failure and stroke. admitted 1/11/14 at 5:00 ation Administration Record) indicated the resident p PPD (Purified Protein 3/14.	R000410	Resident #67 received his tuberculin skin test was completed. Resident #119 received his/her tuberculin sk test was completed. A audit residents residing in the community was completed. Nother residents identified to be affected by deficient practice. Healthwellness director has updated a PPD tracking system to identify residents differ annual tuberculin skin test Healthwellness director will monitor completion of testing weekly X 4, monthly X 1 and quarterly thereafter. Complet by 4/30/2014	of No e em ue

State Form Event ID: IB1V11 Facility ID: 009894 If continuation sheet Page 11 of 12

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/29/2014 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	A. BUILDING B. WING	00	COMPLETED 04/02/2014
	ROVIDER OR SUPPLIER		8480	r address, city, state, zip code CRAIG ST NAPOLIS, IN 46250	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
	Resident #67 indic performed was on				
	review for Resider Diagnoses include	10:00 A.M., the record int #1 was completed. ind, but were not limited to, it is pulmonary disease and			
		ting documentation for attention the last PPD test 2/1/13.			
	There was no doci	umentation the resident 4.			
	Nursing indicated	A.M., the Director of she had no explanation as swere not completed in a			

State Form Event ID: IB1V11 Facility ID: 009894 If continuation sheet Page 12 of 12